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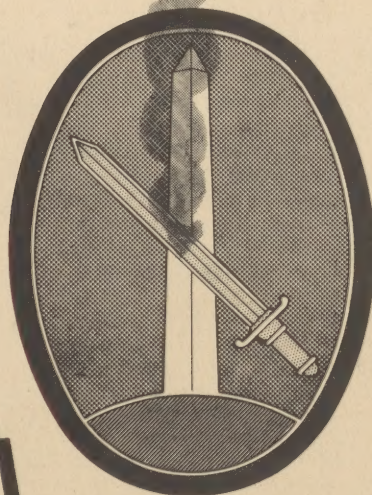
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MONTHLY HEALTH REPORT

Military District of Washington

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October 1949

MONTHLY REPORT

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INTRODUCTION

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HEALTH



HEADQUARTERS, MILITARY DISTRICT OF WASHINGTON
Room 1543, Building T-7, Gravelly Point
Washington 25, D. C.

RESTRICTED

October 1949
Vol. 2, No. 10



INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

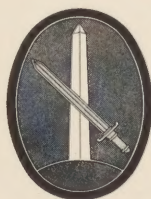
It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as the basis for requisitioning supplies or equipment.

Contributions, as well as suggested topics for discussion, are solicited from Medical Department officers in the field.

FLOYD V. KILGORE
Colonel, MC
Surgeon

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PROFESSIONAL SERVICES

SINUSITIS

Sinusitis is an infection of the lining of the sinuses, the air spaces in the bones of the head and face. These hollows are connected with the nose by small openings; the mucous membrane or lining of the nose is continuous with the lining of the sinuses. Thus, infection of the nose can travel rapidly to the sinuses.

Like other parts of the body, sinuses may get out of order. The air spaces which most commonly become infected are those above the eyes, between and behind the eyes, and in the cheek bones below the eyes.

Inflammation of the nasal passages may close the sinuses, interfering with drainage, and trapping air in the cavity. If a sinus is closed for any length of time, the air in it is absorbed and a vacuum forms, causing severe pain. When inflammation of the lining of a sinus blocks the air space and drainage, pus or other secretion formed may press on the sinus wall, also causing intense pain.

Causes of Sinusitis

Sinus trouble can be caused in a number of ways. Among the most frequent are infections of the nose and throat like the common cold, influenza, measles, scarlet fever, whooping cough, and diphtheria. Exposure and chilling of the skin, poor diet, fatigue, allergies, infected teeth or tonsils, enlarged adenoids, or other nasal obstructions also may cause sinusitis.

Blowing the nose violently, diving, or swimming with the nose under water, all may force infectious material into the sinuses. Frequent use of sprays, oils, and antiseptics in the nose may injure the mucous membrane and bring on sinus trouble.

People who work outdoors are less likely to have sinus infections than those who work in crowded rooms where the air is hot and dry, cold and damp, or full of irritating vapors or dust.

Warning Signs

Although sinusitis is common among men, women, and children of all ages, many persons who believe they have sinus trouble actually do not. While symptoms vary from person to person, there are certain fairly general warning signs of this disease.

Usually there is headache or pain over the infected sinus in the morning, easing in late afternoon. There may be pain in the cheek, upper teeth, or elsewhere in the head. The forehead may be tender to pressure. The nasal passages often are dry and clogged because of the swollen membrane and lack of drainage. There may be a discharge of pus from the nose, or a dripping from the back of the nose into the throat. Sometimes the sense of smell is partially lost. Other symptoms may be fever, cough, swelling of the cheeks, eyelids, or forehead, general fatigue and aching.

An acute infection may clear up or it may develop into chronic sinus trouble. Sometimes a chronic case shows few symptoms except susceptibility to frequent and prolonged colds. But persistent, uncured sinusitis may lead to other, more serious diseases like bronchitis, mastoid infection, and arthritis.

Prevention

You can build up general resistance to sinus infection by observing the rules for good physical and mental health. Get plenty of rest, good food and exercise. Protect your body from sudden changes in temperature, and from exposure to extreme cold or heat. Don't expose yourself to infections. Since colds and other diseases of the nose, throat, and chest are often forerunners of sinus trouble, rest in bed and medical care for respiratory ailments are wise precautions against complications.

PREVENTIVE MEDICINE

IMMUNIZATION

1. General

a. Resistance to communicable diseases depends upon the possession by the body of specific protective substances, the so-called "antibodies," which destroy infections or counteract their poisonous products. The body may possess these protective substances either by manufacturing them itself or by obtaining them from some other person or some animal which has produced them.

b. The human or animal body produces antibodies when stimulated to do so by the presence of a disease-producing germ or its poisonous products. Practically this may occur as a result of having a disease or of introducing into the body some of the dead or greatly weakened germs of the disease or minute amounts of their poisonous products; the latter method is called "vaccination." The immunity or resistance thus developed is spoken of as an "active immunity" because the body produces its own protective substance. Such immunity tends to last a considerable period of time. In some instances this may be a few months, on others a few years, in still others a lifetime.

c. The other type of specific resistance or immunity is obtained by injecting into the body some of these protective substances which have been produced by a person who has had the disease or by an animal into which the germs or their poisonous products have been injected. In either instance the protective substances are found in the blood. If taken from some other person, the liquid part of the blood, with or without the corpuscles, is injected directly. If from animals, the protective substances are removed from the blood, concentrated, and standardized before injection. The resistance or immunity thus obtained is present immediately after the injection but lasts a relatively short time, at most, three to six weeks. The degree of protection or resistance depends upon the quantity of protective substances injected. This so-called "passive immunity" is given when there is need of immediate protection, as when one is actually ill with a disease or when infants, who are particularly susceptible, have been exposed to a disease against which such protective substances are available.

d. Much misinformation and misunderstanding prevail concerning artificial immunizations. Everyone has heard that there are vaccinations or inoculations against certain diseases, but whether they are safe and of established value is not generally known. The question most frequently raised concerning artificial immunization is whether it may not be harmful to inject these dead or weakened germs or their products into the body; particularly is this true when several vaccinations are suggested. This is a natural and perfectly proper question, but the answer is obvious when one considers that when recovery from these diseases occurs it is practically always complete even though enormous quantities of the infection have permeated the body. In vaccinations the quantities introduced into the body are definitely known and are far below the amounts which will cause damage. Such injections do not produce so great or so prolonged an immunity as usually follows an attack of the disease but neither do they carry the hazard of prolonged illness, serious complications, and even death itself that accompanies natural infection. Complications of vaccinations are occasionally reported. The vaccines and methods of vaccination used by the Army lessen the tendency for occurrence of a postvaccinal reaction.

2. Personnel To Be Immunized

a. All military personnel on active duty with the Army.

b. All civilian personnel subject to field service with the Army, including those on transports and in the Army Mine Planter Service.

c. All others who are authorized to travel by vessels or airplanes under the jurisdiction of the Army.

d. All others under military jurisdiction whose immunization may be directed by the local commanding officer upon recommendation of the surgeon.

e. If an outbreak of any disease against which there is an approved immunization procedure occurs in or threatens a military command or troops on a transport, the entire military and civilian personnel, or such part thereof as may be designated by the commanding officer on the advice of the

PREVENTIVE MEDICINE

surgeon, will be immunized or reimmunized with the appropriate agent when this procedure is considered necessary by the surgeon to prevent further spread of the disease. Civilians connected with or residing at such commands, who refuse to be immunized when so directed by the commanding officer, will be excluded from the military station or from embarkation on a transport, or will be subjected to such restrictions as are considered necessary to protect the health of the command.

f. Exemption from immunizations may be granted by the commanding officer upon the recommendation of the surgeon. Such exemptions will be based only upon the presence of definite medical contraindication to the immunizations concerned, and the individual restricted to the extent deemed necessary by the surgeon in the presence of a disease outbreak.

3. Smallpox Vaccination

a. Smallpox is a disease which varies enormously in severity. In prevaccination days it was always severe, being fatal to between twenty and thirty per cent of its victims. The occurrence of smallpox is in no way influenced by climate, soil, age, or occupation. It affects alike the rich and the poor, the clean and the dirty. It spreads wherever the contagion finds susceptible people. The one and only method of controlling it is to raise individual resistance by means of vaccination. There is no possible question concerning the efficiency of vaccination for the prevention of smallpox. In many countries of the world and in certain states of this country vaccination against smallpox is compulsory. In such countries and states smallpox is practically unknown.

b. Immunization against smallpox is completed without unnecessary delay after entry into Federal service. Revaccination against smallpox will be done every three years. Also, revaccination may be administered when there is an outbreak of the disease. If an individual included in paragraphs 2a or 2b above is ordered to a station beyond the continental limits of the United States or to an active theater of operations within the United States, he will be reimmunized providing he has not been immunized within the preceding twelve months. In certain foreign areas where smallpox is prevalent, all military personnel will be revaccinated every six months.

4. Typhoid Fever And The Paratyphoid Fever.

a. The hazard of typhoid fever has been so greatly reduced for civilians by the sanitation of water, milk, and food supplies that few people in civil life consider it necessary to keep up individual resistance by means of vaccination. This is a reasonable course to follow when the sanitary status of one's water, food, and milk supply is known. On the other hand, when in the Army or traveling about, particularly in foreign countries, typhoid vaccination is cheap insurance against a very serious disease.

b. As soon as possible after entry into Federal service, three subcutaneous injections of triple typhoid vaccine are given for typhoid fever and the paratyphoid fevers. They are given at seven to twenty-eight day intervals. Personnel referred to in par 2a and 2b above are revaccinated annually.

5. Tetanus

a. Tetanus is the scientific name for the disease commonly called "lockjaw." The widespread belief that tetanus is most likely to develop in wounds contracted by stepping on a rusty nail in the garden has a scientific basis. The habitat of tetanus germs is in the intestinal tract of horses and other animals that eat vegetable matter. Hence, these germs are likely to occur wherever there are excreta from these animals. Barnyards, highways, fields and gardens in which manure is used as a fertilizer are practically certain to abound with highly resistant forms of this organism.

b. Protection against tetanus may be obtained by the injection of tetanus antitoxin, which contains substances that neutralize the tetanus poison. Such protection is of short duration; hence, the antitoxin is administered only after injuries which are likely to have been contaminated with tetanus germs. In the Army, the use of tetanus antitoxin will be reserved for individuals who are not known to have received an initial series of three injections of tetanus toxoid.

c. An initial immunization against tetanus will be completed without unnecessary delay after entry into the Army. The immunization is accomplished by three subcutaneous injections of

PREVENTIVE MEDICINE

tetanus toxoid administered at intervals of twenty-one to twenty-eight days. A routine stimulating dose of tetanus toxoid is given approximately one year following the completion of the initial tetanus immunization. Following wounds or burns an additional dose of tetanus toxoid will be given if recommended by the surgeon.

6. Typhus, Yellow Fever, Cholera

a. American soldiers who are sent to certain areas are vaccinated against typhus, yellow fever, and cholera.

b. For typhus the soldier is given two doses at an interval of seven to ten days. Stimulating doses should be administered at four to six month intervals in the presence of danger from typhus. If possible, such a stimulating dose should be given before the beginning of the usual typhus season and again in the middle of the season, for maximum effectiveness.

c. For yellow fever the individual is vaccinated ten days or more before reaching the endemic area by one dose of the yellow fever vaccine. Stimulating doses are given every four years.

d. For cholera the soldier is given two doses at an interval of seven to ten days. Stimulating doses are given at four to six month intervals when in the presence of danger of cholera.

7. Plague

Personnel under serious threat of exposure to epidemics of human bubonic or pneumonic plague will be immunized with plague vaccine as prescribed by The Surgeon General. Two doses are given at an interval of seven to ten days. Stimulating doses are given at four to six month intervals in the presence of danger of plague.

8. Influenza

a. Vaccination of military personnel will be undertaken upon evidence of an incipient or beginning of an outbreak of the disease. For installations in the continental United States the vaccination will be effected when directed by The Surgeon General. At overseas installations the decision to employ vaccination against influenza will rest with the overseas commander with the approval of The Surgeon General, or theater or department surgeon.

b. The vaccination consists of a single dose. Precautions are taken to avoid administering influenza vaccine to persons sensitive to eggs. To elicit a history of egg allergy, all persons to be vaccinated should be asked if they are able to eat eggs. The vaccine should be withheld from those who answer in the negative unless further investigation rules out egg sensitivity.

9. Diphtheria

a. Immunization of adults against diphtheria is somewhat more difficult than most other immunization procedures owing to the increased frequency and severity of reactions to diphtheria toxoid which are encountered. For this reason it is desirable, if diphtheria immunization is indicated, and time and facilities permit, to perform a preliminary Schick test and reserve active immunization for those whose Schick reactions are positive, indicating susceptibility to diphtheria. Immunization with toxoid or a Schick negative test is at the present time required only for personnel under the age of thirty-five who are ordered to duty in certain defined areas, for hospital personnel in contact with patients, and for civilian dependents between the ages of three months and fifteen years who travel to any area outside the United States. Organizations experiencing a high incidence of diphtheria should also be immunized. Because of the time required, the meticulous care necessary to obtain reliable results, and other inherent difficulties, mass Schick testing is frequently not feasible.

b. Four doses are administered to those whose preceding dose does not react too severely. The interval between the first and second dose is forty-eight hours. The interval for the remaining doses is three to four weeks. There is usually no stimulating dose.

PREVENTIVE MEDICINE

10. Japanese B Encephalitis

a. Troops are immunized only when in an area where Japanese B encephalitis is known to be prevalent and should be given only in the pre-epidemic and epidemic periods. The seasonal distribution of Japanese B encephalitis is rather sharply limited to the late summer and early fall; consequently vaccination should ordinarily be begun in June.

b. Two inoculations are given seven to ten days apart and a further stimulating inoculation is administered after the completion of the series if the hazard of the disease is still present.

11. Rocky Mountain Spotted Fever

Personnel exposed frequently to infected ticks may be vaccinated for Rocky Mountain spotted fever by three doses at intervals of seven to ten days. Stimulating doses are given annually if indicated.

12. Measles

The prevention or modification of measles in susceptible contacts under special conditions is accomplished by a single injection of immune globulins. There is usually no stimulating dose.

13. Rabies

Rabies vaccine may be given to a person who has been bitten by a rabid animal. Rabies vaccine is administered at the discretion of the medical officer.

14. Time Intervals Between Multiple-Injections and Stimulating Doses

The prescribed time interval between doses of a given agent should be adhered to as closely as possible, but when this cannot be done the omitted dose or doses should be administered as soon as possible and a new series should not be started. Likewise, the lapse of a period of several years beyond the prescribed interval for a stimulating dose of any of these agents does not mean that the initial immunization series need be repeated. If an initial series has been given at any time in the military service, a single dose will suffice to stimulate immunity. The purpose of this paragraph is not to lead to the assumption that regularity in immunizations should not be adhered to as closely as possible.

15. Records

a. WD AGO Form 8-117 (Immunization Register and other Mechanical Data) will be prepared and maintained in duplicate for each individual in the service. The commanding officer of the organization to which the individual is assigned or attached for duty will be responsible for the maintenance of Form 8-117 for all personnel of the command.

b. The original copy of Form 8-117 will be furnished to the individual concerned who will carefully preserve it for reference. The duplicate copy of Form 8-117 will be filed with the enlisted man's Service Record, or with, but not attached to, the Officer's or Warrant Officer's Qualification Card by the personnel section (administrative unit) of the organization to which the individual is assigned or attached.

c. At appropriate intervals the personnel officer will review all record copies to determine the status of all required immunizations and the date when the next injections will be done. He will keep the unit commander informed of these facts so that the immunizations may be properly scheduled. In advance of each scheduled immunization, the personnel officer will obtain the individuals' copies and check their entries against those on the record copies. At the time when immunization is scheduled the individuals' copies will be transmitted to the medical officer, who will enter the immunization performed, authenticate the entries by initialing them, and return the forms promptly to the personnel officer. The personnel officer will have the entries transcribed to the record copy and will deliver the originals to the individuals concerned.

NURSING DIVISION

PREGNANCY AND INFECTIOUS TUBERCULOSIS

1st Lt. Marie V. Hontz, ANC-Res.
Station Hospital, Fort Belvoir, Virginia

The problem of pregnancy and tuberculosis is complex. The outlook in a given case may be favorable or unfavorable, and many factors must be considered before the end result in any particular instance can be foretold.

There seems to be a difference of opinion in the medical profession concerning the best way to handle tuberculous pregnant women. Salmond¹ feels that in cases with active tuberculosis and pregnancy, the tuberculosis must be treated primarily and the pregnancy as a complication.

Gellhorn² thinks that abortion is only rarely indicated in private practice and then only if a patient has a chance of recovery. Social status is important; if the patient is unable to procure proper treatment, it is obviously useless to perform an abortion - she will die anyway. This seems radical at the present time. One may be more conservative in primiparae than in multiparae if abortion is done in the first trimester.

The infectious pregnant tuberculous patient may know that she has tuberculosis; if she does, it is hoped that she will seek medical aid early. Her experience as a tuberculous patient should have taught her something, especially to avoid conditions which will make her disease worse. Others who are not aware of the presence of the disease present another problem. They will have to be educated concerning proper care essential to their well-being. Here, minimizing the strain of pregnancy and conserving strength is important. It is the doctor's problem to decide whether to (1) interrupt the pregnancy, (2) favor conservatism, or (3) endeavor to individualize.

In case of active tuberculosis seen before the third month of gestation, course of treatment is determined only after weighing of all factors which have been carefully noted. It has been suggested that there be a delay on final decision until essential valuable information has been obtained and when there has been a period of close observation. A strict regimen - bed rest, isolation, and dieto-hygienic treatment, is essential. A good, complete history, careful study, complete physical examination with X-Ray, and the use of all diagnostic facilities aid in establishing the proper diagnosis. The treatment of these cases will depend upon the degree to which the tuberculosis has advanced. An abortion may be done if the patient's life can be prolonged thereby, or the child may be allowed to develop and be born. The decision rests with the doctor. If the tuberculosis patient is from one to three months pregnant, a therapeutic abortion can be performed with relative ease and comparatively little danger to the patient; after three months, it is not recommended as it is too difficult and dangerous. The following points are considered: (1) The patient's general condition - if it is poor due to tuberculosis, or if due to weight loss resulting from anorexia, nausea, or vomiting. Toxic and local symptoms may show that the disease is clinically active, and that pregnancy is undesirable. (2) Extent and appearance of the lesion on X-Ray examination. Abortion is usually advised for patients with moderately-advanced or far-advanced active disease. The presence of a cavity may have serious significance. (3) The presence of tubercle bacilli in the sputum will, of course, influence the physician. Each case must be handled individually.

In some instances, induction of pneumothorax or the acceptance of absolute bed-rest and medical treatment may justify the continuation of pregnancy. The economic status of the patient will influence decisions.

For those patients with active or unstable disease, rest in bed, fresh air and proper diet preferably obtained in an institution, is advised. It has been stated that the patient's treatment during pregnancy does not differ significantly from treatment of non-pregnant tuberculous patients - the same precautions and education are essential.

In summary, it can be said that the care of the infectious tuberculous pregnant patient is essentially the same as for other infectious tuberculosis patients. It may be more important to get this patient away from the care of the family, if in so doing you can assure her of the contentment she needs. Her family will have to be taken care of, and she will need such assurance. She should remain in the institution until time of her delivery. If no facilities are available in the institution for her delivery, she should be transferred to a hospital where she can get proper care. In such cases where the patient has been kept in the home, it is vital that she receive guidance and

NURSING DIVISION

proper care.

The Public Health Nurse can be called upon to do some real teaching, as thorough instruction in care and isolation technique is necessary. A good teaching job by the Public Health Nurse who has a good background in tuberculosis nursing will be required if the patient is to receive optimum care. It is just as important for the patient under care at home to have adequate rest, fresh air and diet, as it is for the one in the sanatorium.

The physical strain associated with labor seems to be a factor in the progression of tuberculosis in the month following delivery. The care given the patient during labor will influence her condition later. A postpartum hemorrhage certainly requires immediate attention. Loss of blood, exhaustion, and possibility of aspiration of infectious sputum is to be feared when a completed pregnancy occurs in a woman with pulmonary tuberculosis. By modern handling of the parturient, all of these possibilities can be avoided or danger reduced.

With the loss of blood, a transfusion can be given. Exhaustion will not occur if the labor is properly managed, and the possibility of inhalation of infected materials is indeed small when a skilled anesthetist is employed. These patients must be watched closely for hemorrhage. The puerperal course in the hospital is carried out along the usual line, except that breast-feeding is not permitted and steps are taken to "dry up" the breast milk as soon as it appears. In addition to the possibility of infecting the child, undue strain on the mother must be avoided.

If the patient is under pneumothorax treatment, refills are given at the discretion of the attending physician. At the end of ten days, the patient is given a careful pelvic examination; if involution has progressed normally, she is permitted to return to the sanatorium where she resumes the routine usually employed in tuberculosis therapy.

In the event the mother has been delivered in the home, the Public Health Nurse will be called upon for assistance. Strict isolation technique and expert care is as necessary in the home as in the hospital. This is not always possible - more than that, it is not likely - but the Public Health Nurse can do a good piece of work. The need for education can readily be seen. Every precaution must be carried out to the best of one's ability, no matter where the patient receives care.

It has been found that the tuberculosis process is aggravated during pregnancy or a few months after delivery, therefore it is extremely important that the tuberculosis mother receive careful medical and nursing supervision during the year following delivery - supervision which will be a determining factor in her future health.

When tuberculosis is diagnosed in the mother a few weeks or a few months after delivery, immediate treatment should be made available. A careful follow-up is advised in all cases.

The newborn infant of an infectious tuberculosis mother should be removed immediately from its mother and brought up in an environment free from known tuberculosis. If this is done, the infant will probably thrive. Artificial feedings should be started at once. On discharge from the hospital, the baby should be placed under the care of a private physician or clinic responsible for health supervision of the family. The same precautions are necessary if the baby has been delivered in the home. It may even be advisable to place the infant in a foster home.

The Public Health Nurse has the responsibility of interpreting the physician's instruction for preparation of the infant's food and of giving advice concerning prevention of tuberculosis. Preventive measures for the infant may include: (1) Tuberculin testing of the child at three or four month intervals until the tuberculin test becomes positive, thereafter (2) An X-Ray examination every three or four months for twenty-four months. (3) The baby must be separated from the tuberculous mother until X-Rays show that the mother's disease is stable and there is no danger of transmitting infection. (4) BCG vaccine may be given; it furnishes some protection to the offspring of tuberculous mothers. This is a prophylactic measure only - not a cure. It increases the infant's immunity and should be given beginning one to two weeks after birth. Follow-up is essential. The prognosis is good when contact with the infection is broken.

REFERENCES:

1. Stone and Dufault, "The Prognosis and Treatment of Pulmonary Tuberculosis"

NURSING DIVISION

Chapters 14, 15, and 21; pages 127-153. Lea & Febriger

2. Jameson, Edwin, "Gynecological and Obstetrical Tuberculosis"
Pages 159-201. Lea & Febriger 1935
3. Chadwick, Henry D. and Pope, Alton S., "The Modern Attack on Tuberculosis"
Macmillan

THE NURSE'S PART IN A DERMATITIS CONTROL PROGRAM

Dermatitis is one of the major problems with which the industrial nurse is confronted. Since she is an observer, teacher, and assistant to the physician in establishing control measures in the plant, her role in the program is important.

The industrial nurse can do a great deal in the prevention of dermatitis, especially in plants where known skin irritants are used. On her rounds through the plant and in her daily contact with the employees, she can watch for early symptoms of skin troubles. She can observe dryness, cracking, redness, and enlarged pores, and poor personal hygiene practices, such as neglecting to wash after handling skin irritants. She should also note the condition of the workers' clothing, to see whether it is changed frequently or whether the same garments are worn until they are well saturated with dirt and oil.

As a teacher, the industrial nurse instructs these people in personal hygiene and helps them become aware of their part in a preventive program. If protective creams are supplied, she should demonstrate the correct application, explain the purpose of the creams, and impress the employees with the necessity for keeping them stored so that contamination cannot occur.

The nurse does not diagnose skin lesions, but because of her professional training she can accurately describe types of lesions, indicating where they occur, and when and to what the worker is exposed. Also, she can observe patterns of dermatitis outbreaks in the plant by utilizing her records.

The nurse must have a knowledge of communicable and infectious diseases. She must be able to recognize syphilitic rash, the rashes of contagious diseases, and the symptoms of impetigo, favus, and scabies. In determining the source of infection, the alert nurse can use case histories to advantage. In taking a history, she should find out whether any other members of the family have similar lesions, what symptoms have occurred, and whether the employee has ever reacted in this way before.

She must have a physician's orders for simple treatment of skin irritations. If the patients do not respond promptly, she should refer them to the physician. Many a case has been aggravated and prolonged because of too many types of first-aid treatments.

The industrial nurse must follow up all cases, maintain complete records, get in touch with the physician if he is outside the plant and tell him of her observations of the symptoms and exposure of the employees to an irritant in the plant.

She can observe conditions in the plant that can be of indirect causes of skin irritations--crowding in the wash rooms, insufficient supplies for good washing procedures, the types of soaps and solvents in use (often a cause of irritation to certain types of skin).

The nurse should carefully plan her technique for the care of skin cases in the first-aid room. Supplies should be protected from contamination. Lotions and creams should be correctly applied. She must always bear in mind that a break in technique may be responsible for additional discomfort.

Abstracted from "Trained Nurse and Hospital Review", August 1949.

PREVENTIVE MEDICINE

RESTRICTED

GENERAL COMMENT

The health of the command continued to be satisfactory.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and II installations exclusive of Walter Reed General Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army medical installations do include those Air Force personnel who are treated or hospitalized at the reporting unit on a casual basis, since reciprocal use of either service's medical installations is made. Air Force statistics are tabulated separately for units having Air Force personnel assigned.

The non-effective rate decreased slightly over the August rate of 8.74 to 8.49 for the month of September. Days lost as a result of disease and injury totaled 5429 for the month of September 1949. A total of 4469 days lost was reported for the four week period ending 26 August 1949.

The total admissions for disease and injury in September were 595; of this number 515 admissions were for disease and 80 admissions for injuries. The 595 admissions for all causes (disease and injury) during the report period ending 30 September 1949 were a slight increase from the 575 cases of the previous month. However, the rate for September was 338.6 as compared to 409.2 for August; this difference may be reconciled by reason of August being a 4 week report period and September a 5 week report period. The General Dispensary, USA, continued to report the lowest rate for all causes with 171.5 and Fort Myer (North Post) continued to report the highest with 678.7 for September. The rate at Fort Myer (North Post) was reduced from 1282.1 to 678.7 this present month.

The incidence of injuries increased from 63 cases and a rate of 44.8 in August to 80 cases throughout September for a rate of 45.5. The General Dispensary, USA reported the lowest rate of 5.8 and Fort McNair reported the highest rate of 138.1.

The incidence of disease increased from 512 cases with a rate of 364.4 during August to 515 cases in September with a reduced rate of 293.1. The General Dispensary, USA, The Pentagon, reported the lowest rate of 165.7 and Fort Myer (North Post) reported the highest with a rate of 562.2.

The number of CDD's issued this month totaled 27; this was an increase of 2 over the previous month.

There was 1 death at the reporting installations throughout the five week period ending 30 September 1949.

COMMUNICABLE DISEASE

Common respiratory diseases decreased in incidence during the month of September with 85 cases reported, as compared with 108 for the previous period. The rates were 48.4 and 76.9 respectively.

Admission rates for pneumonia all types decreased during the month of September to 5.1 as compared with the rate of 16.4 in August.

No cases of measles, mumps, scarlet fever or malaria were reported throughout September 1949.

Diarrhea, influenza, tuberculosis and other communicable diseases reflected no appreciable change during the month.

Pertinent Statistical tables may be found on pages 10 and 12.

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RESTRICTED**PREVENTIVE MEDICINE****GENERAL DATA**

5 Week period Ending 30 September 1949
(Data from WD AGO Form 8-122)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of CDD's	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries				
				Cases	Rates	Cases	Rates	Cases	Rates			
Fort Belvoir (A)	8,860	7,244	1,616	256	300.5	224	262.9	32	37.6	14.33	27	1
(AF)	225	225	0	7	322.1	6	272.1	1	46.0	14.98	0	0
Fort McNair (A)	904	822	82	46	529.2	34	391.1	12	138.1	4.11	0	0
(AF)	94	94	0	0	--	0	--	0	--	--	0	0
Fort Myer (North Post) (A)	4,517	1,293	224	99	678.7	82	562.2	17	116.5	6.82	0	0
(AF) **	0	0	0	2	--	2	--	0	--	--	0	0
Fort Myer (South Post) (A)	1,788	1,788	0	94	546.8	88	511.9	6	34.9	2.86	0	0
(AF) **	0	0	0	--	--	--	--	0	--	--	0	0
General Dispensary, USA (A)	3,578	3,551	27	59	171.5	57	165.7	2	5.8	1.74	0	0
(AF)	3,162	3,157	5	64	210.5	60	197.3	4	13.2	1.74	0	0
All Others (A)	1,625	1,625	0	41	262.4	30	192.0	11	70.4	1.32	0	0
(AF)	21	21	0	0	--	0	--	0	--	--	0	0
Total Mil Dist of Wash (A)	18,274	16,323	1,951	595	338.6	515	293.1	80	45.5	8.49	27	1
(AF)	3,503	3,498	5	73	216.7	68	201.9	5	14.8	2.62	0	0
AMC - Med. Det (Duty Pers)	1,543	1,376	167	65	438.1	61	411.1	4	27.0	1.89	0	0
AMC - Det. of Patients	1,059	965	94	147	1443.6	131	1286.5	16	157.1	998.25	158	10
AMC - ROTC, Camp 1 *	102	102	0	0	--	0	--	0	--	8.40	0	0
AMC - Total (Army)	2,196	1,962	234	179	847.7	168	795.6	11	52.1	366.38	120	6
AMC - Total (Air Force)	406	379	27	33	845.3	24	614.8	9	230.5	631.81	38	4
AMC - Total (Army and AF)	2,602	2,341	261	212	847.3	192	767.4	20	79.9	407.40	158	10
Total Dept/Army Units	20,470	18,285	2,185	774	393.2	683	347.0	91	46.2	46.88	143	7
Total Dept/Air Force Units	3,909	3,877	32	106	282.0	92	244.8	14	372.2	67.78	38	4

* ROTC figures not included in Total Dept/Army Units
** Air Force Assigned to Army Medical Installations for medical treatment.

* ROTC figures not included in Total Dept/Army Units

** Air Force Assigned to Army Medical Installations for medical treatment.

ADMISSIONS, SPECIFIED DISEASE - RATE PER 1000 PER YEAR

5 Week Period Ending 30 September 1949
(Data From WD AGO Form 8-122)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diar-rheal Disease	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir (A)	16.4	7.0	5.9	-	-	-	-	3.5	1.2	2.3	1.2	-	4
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort McNair (A)	46.0	11.5	-	-	-	-	-	-	11.5	11.5	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer (North Post) (A)	82.3	6.9	6.9	-	-	-	-	-	6.9	6.9	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer (South Post) (A)	98.9	5.8	5.8	-	-	-	-	-	-	17.5	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
General Dispensary, USA (A)	66.9	-	-	11.6	-	-	-	-	-	-	-	-	-
(AF)	55.9	3.3	3.3	10.0	-	-	-	3.3	-	-	-	-	-
All Others (A)	96.0	-	-	-	-	-	-	-	-	6.4	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Mil Dist of Wash (A)	48.4	5.1	4.0	2.3	-	-	-	1.7	1.1	4.0	1.1	-	4
(AF)	56.4	3.0	3.0	8.9	-	-	-	3.0	-	-	-	-	-
AMC - Med. Det. (Duty Pers)	-	-	-	-	-	-	-	-	-	-	6.7	-	3
AMC - Det. Of Patients	9.8	9.8	9.8	-	-	-	-	-	-	-	9.8	9.8	5
AMC - ROTC, Camp 1	-	-	-	-	-	-	-	-	-	-	-	-	-
AMC - Total	4.0	4.0	4.0	-	-	-	-	-	-	-	8.0	4.0	8
AMC - Total (Air Force)	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Dept/Army Units	43.7	5.1	8.1	71.1	-	-	-	1.5	1.0	3.6	1.0	1.0	13
Total Dept/Air Force Units	47.9	2.7	2.7	8.0	-	-	-	2.7	-	-	-	-	-

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PREVENTIVE MEDICINE

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VENEREAL DISEASE

Venereal disease rate among units within the Military District of Washington decreased over the August rate. The rate for September 1949 was 20.49, for August the rate was 23.48. All units reported a lower rate this month with the exception of Fort Belvoir. In September 1948 the consolidated total for the Military District of Washington was 18.42, a slight decrease over the present September rate of 20.49.

A total of 37 cases were reported for the five week period ending 30 September 1949. Of this total 34 cases were reported at Fort Belvoir, 2 at Fort Myer (South Post) and 1 at units listed as "All Others". Of the total number of cases reported, 16 were incurred by white personnel, with a rate of 9.56 and 21 were incurred by negro personnel, with a resulting rate of 111.94 per 1000 troops per annum.

Of the 37 cases of venereal disease reported, 7 were diagnosed as syphilis and 30 as gonorrhea.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we are undertaking in this issue to report number of cases per 100 men for this report period in addition to the rate per 1000 men per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 12, 13, 14 and 15

NEW VENEREAL DISEASE CASES - EXCL EPTS - JULY, AUGUST, AND SEPTEMBER

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 100 Troops
	JULY 49	AUGUST 49	SEPTEMBER 49	SEPTEMBER 49
Fort Belvoir	28.42	36.97	39.91	.384
Fort McNair	12.11	30.02	-	-
Fort Myer (North Post)	13.86	-	-	-
Fort Myer (South Post)	11.30	28.57	11.64	.112
General Dispensary, USA	-	-	-	-
All Others	7.00	-	6.40	.062
Total Mil Dist Wash Units	17.23	23.48	20.49	.202
AMC Med. Det. (Duty Pers.)	19.86	27.84	26.96	.259
AMC Detachment of Patients	-	32.18	39.28	.377
Army Medical Center - Total	13.67	29.43	31.98	.307
Total Dept/Army Units, Mil Dist of Washington	16.85	24.13	23.35	.215

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CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY
MDW RATE PER 1000 TROOPS PER YEAR

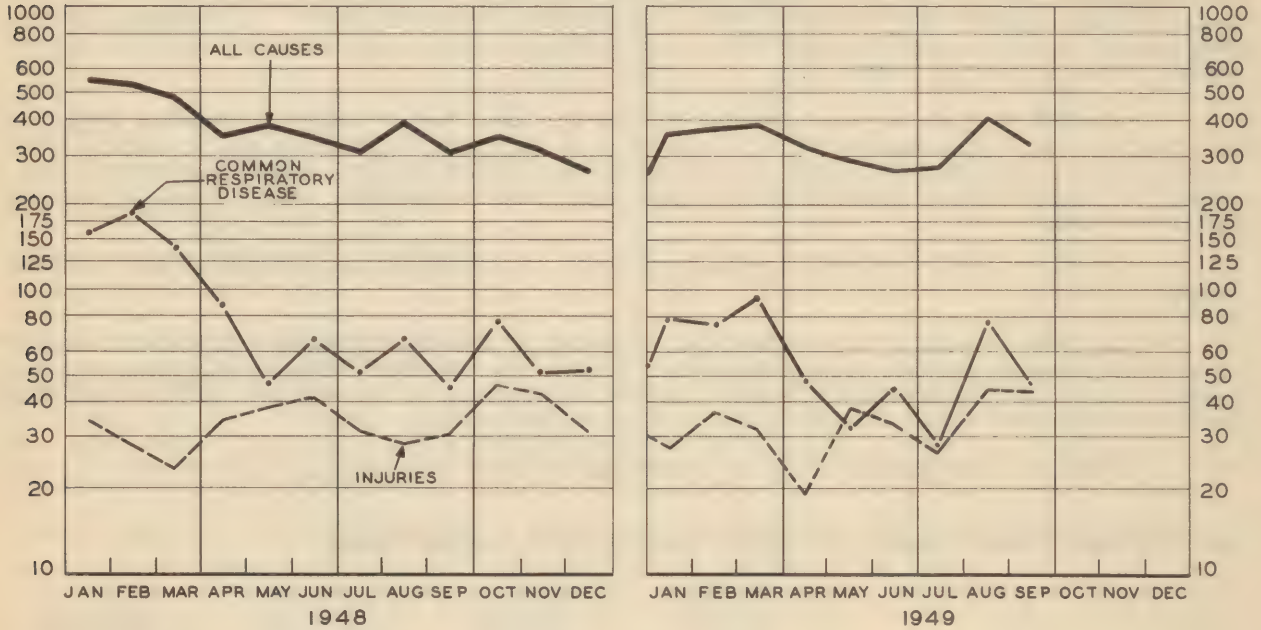
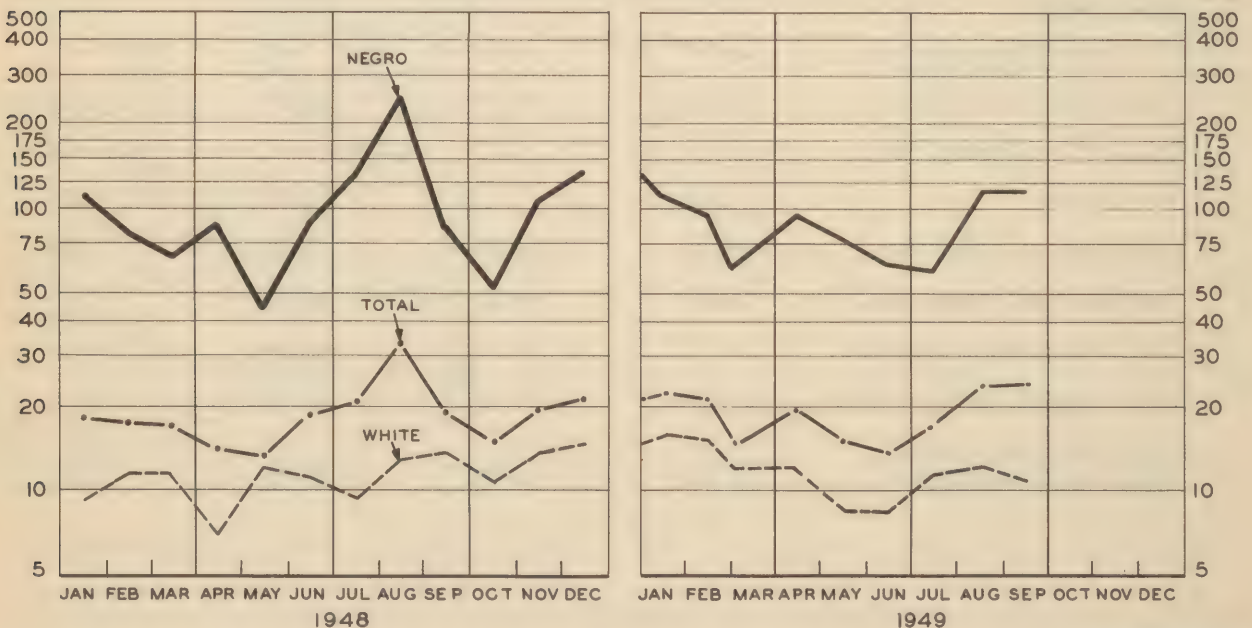


CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW INCL. ARMY MEDICAL CENTER
RATES PER 1000 TROOPS PER YEAR
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



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CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT

For the Five Week Period Ending 30 September 1949
(Data from WD AGO 8-122) (Chargeable Cases)

STATION	R A C E	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
			Syphilis	Gonorrhea	Other	Total		
Fort Belvoir	W	7,244	3	10	0	13	18.66	10
	N	1,617	4	17	0	21	135.06	9
	T	8,861	7	27	0	34	39.91	19
Fort McNair	W	822	0	0	0	0	-	0
	N	82	0	0	0	0	-	0
	T	904	0	0	0	0	-	0
Fort Myer (North Post)	W	1,293	0	0	0	0	-	0
	N	224	0	0	0	0	-	0
	T	1,517	0	0	0	0	-	0
Fort Myer (South Post)	W	1,787	0	2	0	2	11.64	0
	N	0	0	0	0	0	-	0
	T	1,787	0	2	0	2	11.64	0
General Dispensary, USA	W	3,551	0	0	0	0	-	0
	N	27	0	0	0	0	-	0
	T	3,578	0	0	0	0	-	0
All Others	W	1,625	0	1	0	1	6.40	0
	N	0	0	0	0	0	-	0
	T	1,625	0	1	0	1	6.40	0
Total Mil Dist of Wash	W	16,323	3	13	0	16	9.56	10
	N	1,951	4	17	0	21	111.94	9
	T	18,274	7	30	0	37	20.49	19
Army Medical Center Medical Det. (Duty Pers) (A) (AF)	W	1,376	0	1	1	2	15.12	0
	N	167	0	2	0	2	124.55	17
	T	1,543	0	3	1	4	26.96	17
Army Medical Center Detachment of Patients (A) (AF)	W	965	1	0	0	1	10.78	170
	N	94	0	2	1	3	331.91	242
	T	1,059	1	2	1	4	39.28	412
Army Medical Center - Total (A) (AF)	W	2,341	1	1	1	3	13.33	170
	N	261	0	4	1	5	199.23	259
	T	2,602	1	5	2	8	31.98	429
Total Dept/Army Units	W	18,285	3	13	2	19	10.81	180
	N	2,185	3	20	0	25	119.00	218
	T	20,470	6	33	2	44	23.35	398

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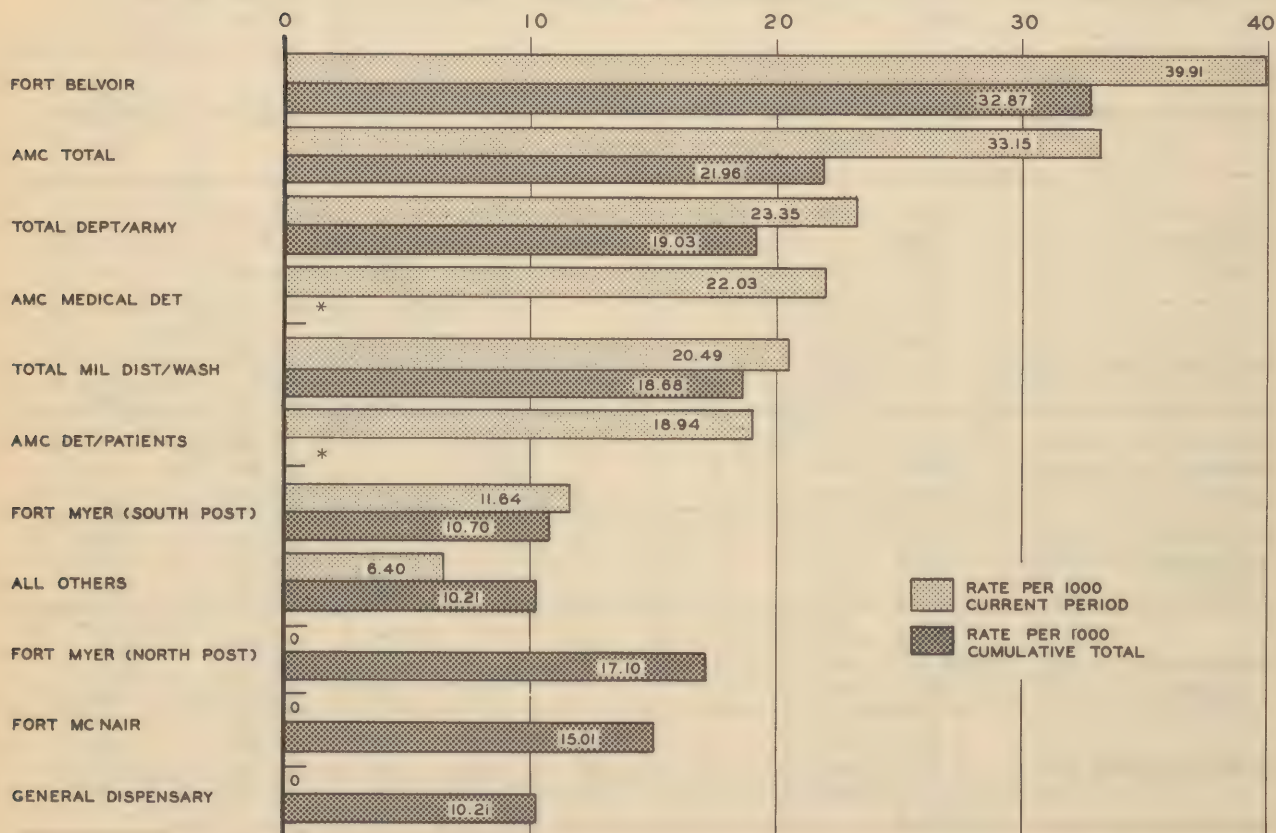
VENEREAL DISEASE RATES FOR US *

(All Army Troops)

	AUGUST 1949	SEPTEMBER 1949
First Army Area	17	16
Second Army Area	25	20
Mil District of Washington	24	22
Third Army Area	30	26
Fourth Army Area	22	22
Fifth Army Area	17	19
Sixth Army Area	21	22
Total United States	23	21

* Compiled in the Office of the Surgeon General and includes General Hospitals.

VENEREAL DISEASE RATES PER 1000 PER YEAR FIVE WEEK & CUMULATIVE TOTALS ENDING 30 SEPTEMBER 1949 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)

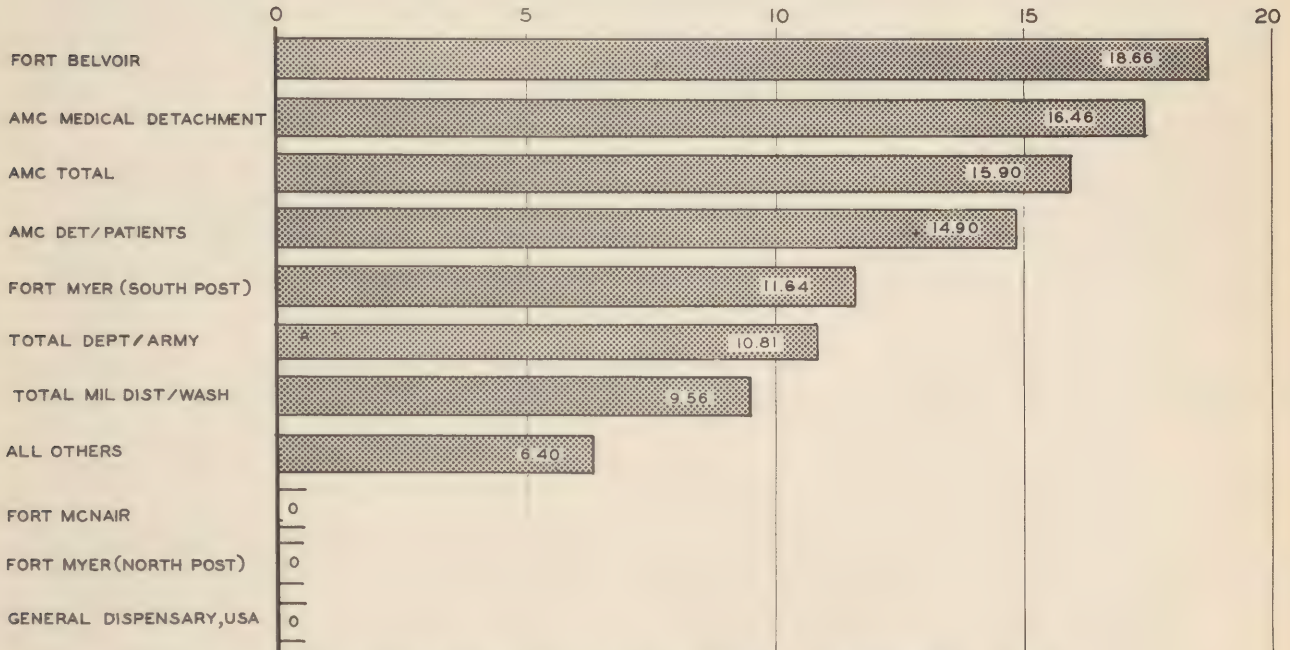


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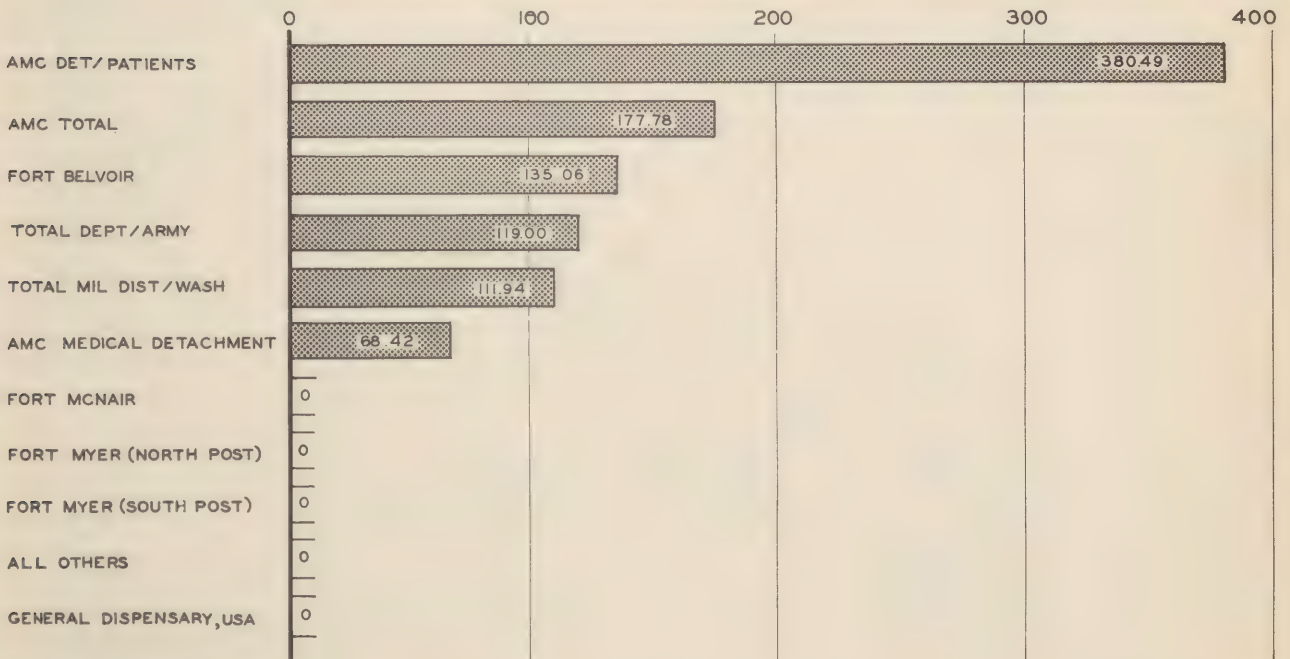
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VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 5 WEEK PERIOD ENDING 30 SEPTEMBER 1949 WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 5 WEEK PERIOD ENDING 30 SEPTEMBER 1949 NEGRO PERSONNEL CHARGEABLE CASES



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VETERINARY SERVICE

TULAREMIA

Tularemia is primarily a disease of wild rodents, especially rabbits, and is capable of causing infection in man. The causative organism is *Pasteurella tularensis*. The disease was first recognized in 1910 and at that time was known by several names such as "plague-like disease of rodents", "deer-fly fever", and "glandular-type tick fever". McCoy and Chapin working in Tulare County, California, in 1912, isolated the causative agent.

Tularemia is reported from all states of this country with the exception of Vermont. It has been reported in a great number of countries throughout the world.

There is no seasonal prevalence for tularemia but in those areas where deer flies and ticks are prevalent, it is reported most often during the summer season when these insects are numerous. In those parts of the U.S. where the jack rabbits and cottontail rabbits are found, tularemia is reported in increased numbers during the hunting season which is usually during the fall or winter months. It has been estimated that one percent of all wild rabbits have tularemia. Although domestic rabbits are susceptible they have not been reported as having acquired the disease naturally.

Tularemia has been found in the United States in most of the wild rodents. The organism has been isolated from the sage hen, quail, grouse and pheasant. Domestic poultry is apparently immune. Of the domesticated animals, sheep are reported as the most often infected.

The transmission of the disease from animal to animal is thought to be carried on by means of blood sucking insects, such as lice, flees, ticks and mechanically by biting flies.

Francis reports that there are at least twenty means by which man can acquire tularemia. Handling and dressing infected wild rabbits, is perhaps the most common. Other possibilities include insect bites, laboratory infections, ingestion, bites from infected animals, handling wild and domesticated animals that are infected with the disease.

The incubation period in man is about three days. Symptoms include, headache, vomiting, fever, chills and aches and pains in various parts of the body. The infection develops at the point of entrance and the associated lymph glands of the area become enlarged and painful. Several clinical types are reported in man. Mortality is about seven percent. The disease lasts about three weeks with convalescence requiring from two to three months. Uncomplicated cases recover with no after effects and are followed by immunity against future exposure.

This disease can be prevented in man by avoiding contact with infected animals. Rubber gloves should be worn when handling susceptible animals and while working with the organism in the laboratory. The hands should be thoroughly washed with soap and water after all contact with such animals and materials. All scratches and wounds of the hands should be treated with a disinfectant. Thorough cooking of the meat of animals and fowls susceptible to the disease will render it safe for eating. Considerable protection is provided by vaccine but there are disadvantages to its general use. In those areas where the disease is most common the prohibiting of the sale of wild rabbits has been effective in reducing the morbidity in the treatment of this disease.

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED SEPTEMBER 1949
(Data obtained from WD AGO Form 8-134)

	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		63,119	73,091		136,610	100,800		374,020
Fort Belvoir, Virginia		228,091	191,479		470,492	85,895		975,873
Potomac Yards Distribution Point		271,661	73,175	354,357			98,598	798,261
Fort Myer, Virginia		179,659	153,683		319,332	9,620		666,300
Mill Dist/Washington Vet Det	290,526							290,526
US Navy	140,520							140,520
The Pentagon						271,370		271,370
Total	431,046	742,890	491,424	354,897	926,440	467,645	98,598	3,512,880
Army Medical Center		196,659	79,001		275,640	6,089		571,369
Washington Quartermaster		119,137	69,679	340	186,633	8,503		380,292
Bolling Air Force Base		129,443	106,637		244,473	113,334	3,654	597,541
Total		445,219	255,317	340	706,746	123,926	3,654	1,535,202
Grand Total	431,046	1,188,109	746,741	355,177	1,633,186	591,571	102,252	5,048,082
REJECTIONS:								
Insanitary or Unsound								
Army Medical Center		74				48		122
Bolling AF Base						61		61
Mill Dist/Washington Vet Det	60							60
Not type, class or grade								
Washington Quartermaster			54					54
The Pentagon						771		771
Bolling AF Base						238		238
Potomac Yards Dist. Point		1,596						1,596
Mill Dist/Washington Vet Det	9,290							9,290
Fort Myer, Virginia		232						232
TOTAL REJECTIONS	9,350	1,596				1,118		12,424

DENTAL SERVICE

PREVENTION OF TOOTH DECAY IS NOW SAID TO BE POSSIBLE

The longtime search for a preventative for tooth decay may be over with according to the results of research, on a tooth paste containing chlorophyll, made by Dr. Gustav W. Rapp, professor and research biochemist of Loyola University's dental school, and his assistant, B. F. Gurney.

The new tooth paste acts to do away with all of the conditions generally thought by dental authorities to be causes of dental decay, according to Dr. Rapp and Mr. Gurney who delivered their reports at the annual meeting of the International Association for Dental Research.

The tooth paste owes its unusual powers to the use of the water-soluble derivations of chlorophyll, the green substance that gives grass and other green plants their color. Long known as essential to all life, chlorophyll has previously been used with excellent results in medical treatments.

Already on the market from coast to coast, the tooth paste has been sold during the past year primarily on the recommendation of dentists. It has previously been known chiefly for its ability to accelerate healing of various gum disorders including non-specific gingivitis and trench mouth.

Its newly-found properties include a greater ability to lower the acid count of the mouth than any other known substance and a similar ability to act in preventing the formation of the bacterial acids associated with tooth decay. The tooth paste, which has a natural green color, also retards the breakdown of the protein part of tooth enamel. Both the formation of bacterial and protein breakdown are assumed by dental authorities to be causes of decay.

Dr. Rapp indicated further that early results of additional studies show that the tooth paste also inhibits pathogenic bacteria, such as streptococci and staphylococci aureus, the third presumed cause of cavities.

The new tooth paste, in addition to all these properties, actually deodorizes the mouth and retards the return of offensive odors. All of these advantages may be had, according to the report, with only two brushings a day, one of them preferably after breakfast when the acid count of the mouth is at its highest.

Prior to Dr. Rapp's report, chlorophyll was chiefly known for its mysterious action in a process known to scientists as photosynthesis, by which green plants convert the energy of the sun's rays into stored food energy. It has long been known that without chlorophyll neither plants nor animals (including human beings) could live, for this conversion of the energy of the sun into food is basic for all life.

In dealing with the work on acid count, Dr. Rapp's figures showed that two brushings a day with the chlorophyll tooth paste resulted in a negative lactobacillus acidolophus (the bacteria associated with tooth decay) count in 26 per cent of his subjects within 10 days. By the end of the fourth week of his studies, the number had jumped to 42 per cent, while at the end of the 26th week, 90 per cent of the subjects were free of the acid and had been for quite a while.

The studies on the deodorizing properties of the chlorophyll tooth paste showed that a single brushing lowered mouth odor considerably below the point felt to be objectionable and held it there for more than two hours. A control paste, chosen out of several commercial brands for its superiority in lowering mouth odor, demonstrated its complete inability to compare with the new paste in this respect.

Abstracted from "Trained Nurse and Hospital Review", August 1949.

DENTAL SERVICE--MONTH OF SEPTEMBER 1949

STATION	Offi- cers	Days of Duty	Sit- tings	Amal- gam	Oxy and Amal	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures			Extrac- tions	Calcu- lus Removed	X-Rays	Exami- nations
											Full	Par- tial	Re- pair				
Fort Belvoir	9	256	1,572	469	372	319	2	13	0	8	10	19	6	331	140	437	807
Fort McNair	2	57	436	430	181	104	-	-	-	1	1	4	-	66	37	149	120
Fort Myer (North Post)	1	30	852	206	60	34	-	-	2	-	1	19	-	58	16	613	278
Fort Myer (South Post)	2	37	324	246	41	66	-	-	-	-	4	9	-	49	8	109	79
General Dispensary, USA	4	115	1,899	393	164	109	2	12	0	12	2	21	1	95	135	658	818
All Others	1	30	84	24	65	27	-	1	-	-	-	2	-	58	14	18	49
Total Mil Dist of Wash	19	523	5,167	1,768	886	659	4	26	2	21	18	74	7	657	350	1,984	2,151

ADMINISTRATIVE DIVISION

PERSONNEL NOTES

With this volume of the Military District of Washington Monthly Health Report, the Surgeon's Office, Personnel Section inaugurates a new feature, Personnel Notes. It is hoped that these notes covering the assignment and reassignment of Medical Department Personnel within the Command will become a matter of interest as well as constituting useful information to Medical Department Personnel.

During the month of September 1949, the following personnel joined the Military District of Washington units indicated:

NAME	RANK	BRANCH	ORGANIZATION
McClary, Allen R.	Captain	MC	7011 ASU Ft. Myer
Price, Walter S.	Captain	MC	7011 ASU Ft. Myer
Priest, Edwin R.	1st Lieutenant	MC	7011 ASU Ft. McNair
De Marco, Dominic E.	1st Lieutenant	DC	7071 ASU Ft. Belvoir
Fastiggi, Caesar	1st Lieutenant	DC	7025 ASU So. Post, Ft. Myer
Garvey, Andrew Jr.	1st Lieutenant	DC	7071 ASU Ft. Belvoir
Hayes, Salby C.	Captain	ANC	7071 ASU Ft. Belvoir
Burk, Margaret E.	1st Lieutenant	ANC	7071 ASU Ft. Belvoir
Gwinn, Alma E.	1st Lieutenant	ANC	7071 ASU Ft. Belvoir
Neff, Joseph K.	1st Lieutenant	ANC	7071 ASU Ft. Belvoir

The Military District of Washington lost the following personnel through reassignment or separation during September.

NAME	RANK	BRANCH	ORGANIZATION
McMillan, T. M.	Captain	MC	7004 ASU GDUSA - Separated
Tkach, W. R.	Captain	MC	7004 ASU GDUSA - Transferred to Randolph AFB, Texas
Mills, S. W.	Captain	MC	7004 ASU GDUSA - Separated
Perkin, J. W.	Captain	MC	7021 ASU Ft. McNair - Separated
Larnce, P. C.	Major	MSC	7004 ASU GDUSA - Transferred to Office of the Air S.G., Pentagon
Thomas, W. R.	1st Lieutenant	MSC	7001 ASU Hq. MDW - Transferred to EUCOM
Barrett, T. A.	1st Lieutenant	ANC	7071 ASU, Ft. Belvoir - Transferred to 3440 ASU, Ft. Benning, Ga.

OUTPATIENT SERVICE

Consolidated statistical data on the outpatient service, Military District of Washington, less Walter Reed General Hospital for the five week period ending 30 September 1949, are indicated below:

ARMY:	NON ARMY:
Number of Outpatients..... 5,418	Number of Outpatients..... 4,968
Number of Treatments..... 19,314	Number of Treatments..... 15,338
NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED..... 1,864	
NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED..... 7,142	

HOSPITAL MESS ADMINISTRATION (Data from WD AGO Form 8-210)

STATION	June 49	July 49	August 49	September 49
FORT BELVOIR				
Income per Ration	\$ 1.061	\$ 1.090	\$ 1.088	\$ 1.192
Expense per Ration	1.045	1.029	1.047	1.104
Gain or Loss	+ 0.016	+ 0.061	+ 0.041	+ 0.088

ADMINISTRATIVE DIVISION

Selected list of titles received by Army Medical Library, Washington 25, D. C., which were published during the last three years.

- Akerblom, Bengt
Standing and sitting posture;
with special reference to the
construction of chairs. Stock-
holm, Nordiska bokhandeln,
1948. 187 p.
- Brownell, C. L.
Principles of health edu-
cation applied. 1st ed.
New York, McGraw-Hill, 1949.
366 p.
- Buxton, C. L. & Engle, E. T.
Diagnosis and therapy of
gynecological endocrine
disorders. 1st ed. Spring-
field, Ill., C. C. Thomas,
1949. 62 p.
- Duke-Elder, Sir W. S.
Text-book of ophthalmology.
v. 4. St. Louis, Mosby,
1949.
- Dunbar, H. F.
Your child's mind and body;
a practical guide for parents.
New York, Random House, 1949.
324 p.
- Fulton, J. F.
Functional localization in
the frontal lobes and cere-
bellum. Oxford, Clarendon
Press, 1949. 140 p. (Wil-
liam Withering memorial
lectures, 1948)
- Gerard, R. W.
Unresting cells. New York,
Harper, 1949. 439 p.
- Hanby, J. H. and Walker, H. E.
The principles of chiropody.
London, Bailliere, Tindall and
Cox, 1949. 383 p.
- Harrison, Gene and Harrison, J. H.
The nurse and the law. 2d ed.
Philadelphia, F. A. Davis, 1948.
368 p.
- Illinois. Dept. of Finance
A budget survey of state
mental hospitals, presenting
the replies from the forty-
eight states on the question-
naire "Commodity costs and
budgeting for state mental
hospitals." Springfield, 1948.
97 p.
- Kelly, G. L.
Sex manual for those married
or about to be, written for
the layman. 4th ed., rev.
Augusta, Ga., Southern Medical
Supply Co., 1948. 84 p.
- Keynes, G. L. ed. and others
Blood transfusion. Baltimore,
Williams and Wilkins, 1949.
574 p.
- Kuntz, Albert
The neuroanatomic basis of
surgery of the automatic
nervous system. 1st ed.
Springfield, Ill., C. C.
Thomas, 1949. 83 p. (Ameri-
can lecture series, no. 33.
American lectures in anatomy)
- Mosby (C. V.) Company
Comprehensive review of
nursing. St. Louis, 1949.
704 p.
- Northwestern University, Evan-
ston, Ill. Subcontractor's
final report on a review of
the literature, patents, and
manufactured items concerned
with artificial legs, arms,
arm harnesses, hands and hooks;
mechanical testing of artifi-
cial legs. Covering the period
from December, 1945 through
June, 1947. Washington, 1947.
2 v. (National Research Council
Committee on Artificial Limbs.
(Final report, no. 10))
- Randall, Margaret
Ward administration. Phila-
delphia, W. B. Saunders, 1949.
326 p.
- Rienzo, S. di
Radiologic exploration of
the bronchus. Tr. by Thomas
A. Hughes. Springfield,
Ill., C. C. Thomas, 1949.
332 p.
- Rosenberg, Henrietta
Sex studies from Freud to
Kinsey, by Walter S. Keating
(pseud.) New York Stravon,
1949. 92 p.
- Schnitzer, Kurt
Electrocardiographic techni-
que; a manual for physicians,
nurses and technicians. New
York, Grune & Stratton,
1949. 96 p.
- Stone, C. P.
Case histories in abnormal
psychology. Stanford,
Calif. Stanford Univ.
Press, 1949. 106 p.
- Thomas, E. W.
Syphilis: its course and
management. New York,
Macmillan, 1949. 317 p.
- Tidy, H. L.
A synopsis of medicine. 9th
ed. Baltimore, William and
Wilkins, 1949.
- Turell, Robert and Linn, Louis
Treatment in proctology,
with a chapter on psychoso-
matic problems. Baltimore,
Williams & Wilkins, 1949.
248 p.
- Wertham, Frederic
The show of violence. 1st
ed. Garden City, N. Y.
Doubleday, 1949. 279 p.
- Widdess, J. D. H.
An account of the Schools of
Surgery, Royal College of
Surgeons, Dublin, 1789-1948;
a Dublin school of medicine
and surgery. Edinburgh, E.
& S. Livingstone, 1949. 107 p.
An expansion of three lec-
tures given for students
of the school.

ADMINISTRATIVE DIVISION

Following is a list of publications which are of particular interest to the Medical Department;

Cir No.	DEPARTMENT OF THE ARMY CIRCULARS Subject	Date
97	Section II Clinical Record Forms	1 Sept 49
97	Section IV Department of Defense	1 Sept 49
98	Fire Prevention Week	6 Sept 49
102	Reconciliation of Official Titles and Locations Applicable to Fiscal Station Numbers	26 Sept 49
103	Council Book DD Form 251	26 Sept 49
104	Statements of Income Tax Withheld from Military Personnel from 1 January through 30 June 1949	27 Sept 49

SR No.	DEPARTMENT OF THE ARMY SPECIAL REGULATIONS Subject	Date
40-1005-1	Medical Service, Essential Technical Medical Data Report	2 Sept 49
40-225-20	Medical Service, Prevention of Dissemination of Communicable Diseases by Persons Proceeding to Greenland	23 Sept 49
40-590-45 C11	Medical Department, Treatment for Department of the Army, Active Reserve, Retired Personnel of the Navy and Marine Corps	30 Sept 49

Memo No.	MILITARY DISTRICT OF WASHINGTON MEMORANDA Subject	Date
47	Administrative Vehicle Control	9 Sept 49
49	Loan of Quartermaster Property on Memorandum Receipt to Military Personnel on Duty in MDW	14 Sept 49
51	Distribution List	19 Sept 49
52	Wearing of the Winter Uniform	21 Sept 49
53	List of Officers Under Jurisdiction of MDW	27 Sept 49

Cir No.	MILITARY DISTRICT OF WASHINGTON CIRCULARS Subject	Date
48	Submission of Personnel Requisitions and Report of Surplus Enlisted Personnel	1 Sept 49
54	Promotion of Enlisted Personnel	29 Sept 49
55	Separation by Reason of Physical Disability	30 Sept 49

ANWMC File No.	PUBLICATIONS ORIGINATED IN OFFICE OF SURGEON, MDW Subject	Date
701	Summary of the Several Aspects of Medical Care	9 Sept 49